JANET WESTENBERGER, D.O.
Westwood Medical Park
3875 North Buffalo Road, Orchard Park, NY 14127
PH: 716-662-9336 FX: 716-662-9236

Patient Name: _____ Today's Date: _____
First Name Middle Initial Last Name

Sex: □ M □ F Sex Orientation _____ Age: _____ Birthdate: _____ □ Single □ Married □ Other: _____

Home Address: _____City_____ State _____ Zip _____

Home#: _____ Cell#: _____ Work#: _____ Best # to be reached: H - C - W

Email Address: (This is important so we can communicate with you through the patient portal):_____

Race: White - African American - Hispanic - Asian - Indian - Other: _____ Preferred Language: _____

Pharmacy Name, Address, Phone#: _____

Are you employed? ___Yes or ___ No? Employer: _____Occupation: _____

Spouse: _____ Birthdate: _____

Spouse's Employer Name/Occupation: _____

Who is responsible for this account? _____ Relationship to patient: _____

Patient's Social Security #: _____ Spouse's Social Security #: _____

Do you have Medical Insurance? □ No □ Yes If yes,

Name of Insurance Carrier: _____ ID#: _____

Policy Holder Name: _____DOB: _____ Group # _____

Name of Secondary Insurance (In Any): _____ ID#:___ _____

Policy Holder Name: _____DOB: _____ Group # _____

In case of emergency, who should we notify? _____ Phone: _____

How did you learn of our practice? _____

Do you have any communication barriers? None _____ Hearing? _____ Vision? _____ Other: _____

Level of school completed? _____ What grade _____Years in College _____ GED

Patient/Guardian Signature: _____ Date: _____

Authorizations

Insurance Assignment and Release

I certify that I have insurance coverage with _____
(Name of Insurance Company)
and assign directly to Dr. Janet Westenberger all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will not end unless I terminate Dr. Janet Westenberger as my doctor.

Medicare/ Medigap Authorization
I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Dr. Janet Westenberger for any services furnished to me by Dr. Janet Westenberger and/or her office (staff).

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____
(Signature of Beneficiary, Guardian or Personal Representative) (Date)